Planned Parenthood®
Southeastern Pennsylvania

STI HISTORY & PHYSICAL

Patient Name:____________________ **Age:**______ **Medical Record #:**______________ **Date:**______________

SUBJECTIVE/CHIEF COMPLAINT: Why are you here today? ☐ **Routine Screening** ☐ **Problem** ____________________

How do you identify? ☐ Female ☐ Male ☐ Transgender Other, please identify: ____________________

No	Yes	
☐	☐	Are you receiving medical care with another health provider? Reason for visit(s): ____________________
☐	☐	Are you allergic to any medications, metals, foods, anesthesia or other products? List: ____________________
☐	☐	Are you currently taking medications (including herbal remedies and vitamins)? List: ____________________

FAMILY HISTORY – Has your Grandmother/father (GM/GF), Mother (M), Father (F), Sister (S), or Brother (B) been diagnosed with any of the following?

No	Yes		
☐	☐	Breast cancer	family member:____________
☐	☐	Ovarian cancer	family member:____________
☐	☐	Uterine cancer	family member:____________
☐	☐	Prostate cancer	family member:____________
☐	☐	Testicular cancer	family member:____________

PAST MEDICAL HISTORY – Have **YOU** been diagnosed or treated for any of the following:

No	Yes	
☐	☐	Kidney / Urinary Tract problems or infections
☐	☐	Genital problems / surgery
☐	☐	Pelvic infection / PID
☐	☐	Abnormal Pap smear
☐	☐	Serious illness or hospitalization
☐	☐	Vaccination for Hepatitis B

REVIEW OF SYSTEMS

No	Yes	
☐	☐	Constitutional: Fever/Weight Change/ Fatigue
☐	☐	Oral: Ulcers / Sores in your mouth
☐	☐	Skin: Rash / Itching

HEALTH HABITS / SOCIAL HISTORY

No	Yes	**Do you:**
☐	☐	Douche.
☐	☐	Smoke: __________ cigarettes per day.
☐	☐	Alcohol intake: __________ drinks per week.
☐	☐	Drug use: daily / weekly / monthly. Type ____________________
☐	☐	Alcohol and/or drugs cause problems in your life?
☐	☐	Others concerned with your alcohol/drug habits?
☐	☐	Afraid of your partner(s) / others?
☐	☐	Parent(s) or guardian is aware of your visit (Only answer if under age 18.)

SEXUAL HISTORY

Date you last had sex ____________________

# of sexual partners in last 30 days: ______________

# of sexual partners in last 12 months: ______________

# of partners in your lifetime: ______________

Partner(s) – Check all that apply: ☐ Male ☐ Female ☐ Transgender ☐ Intersex

Kind of sex: (please indicate all that apply:
☐ Vaginal (Giver/ Receiver)
☐ Anal (Giver/ Receiver) ☐ Oral (Giver/ Receiver)

No	Yes	**Do you or have you:**
☐	☐	Consistently use condoms/dental dams for safer sex?
☐	☐	Ever exchanged sex for money or something else you wanted?
☐	☐	Ever been forced to have sex?
☐	☐	Ever had a partner that had more than 1 partner?
☐	☐	Have any of your partners used IV drugs?

INTERVIEWER COMMENTS

CONTRACEPTIVE HISTORY

Current method of birth control: ____________________

MENSTRUAL HISTORY

☐ Check here if this section is not applicable.

When was the **1st day** of your last period? ____________

No	Yes	
☐	☐	Was your last period normal?
☐	☐	Do you think you might be pregnant?

STI HISTORY – Have you ever had the following?

No	Yes		
☐	☐	Chlamydia	Date last treated: ______________
☐	☐	Gonorrhea	Date last treated: ______________
☐	☐	Herpes	Date last treated: ______________
☐	☐	HPV/warts	Date last treated: ______________
☐	☐	Syphilis	Date last treated: ______________
☐	☐	Trichomonas	Date last treated: ______________
☐	☐	HIV	Date last treated: ______________
☐	☐	Hepatitis	Date last treated: ______________

STI TREATMENT

No	Yes	
☐	☐	Are you here for STI treatment?
☐	☐	Is your partner(s) being treated for an STI? Date of treatment ______________ Name of infection ______________

HISTORY OF CURRENT COMPLAINT- Do you have any of the following?

No	Yes	
☐	☐	Genital sores, itching or pain.
☐	☐	Penile/Vaginal discharge.
☐	☐	Scrotal/Testicular enlargement.
☐	☐	Pain / bleeding with sex.
☐	☐	Pain, burning, difficult or frequent urination.
☐	☐	A fever or any flu-like symptoms.

Date symptoms first noticed: ____________________

I would like the following STI screening today:

☐ Chlamydia
☐ Gonorrhea
☐ HIV
☐ Syphilis

I would like information on the following:

	Given (Staff Initials)
☐ Chlamydia	__________
☐ Gonorrhea	__________
☐ HIV	__________
☐ HPV / warts	__________
☐ Syphilis	__________
☐ Breast Self Exam	__________
☐ Testicular Self Exam	__________

Patient Signature: ______________________________ **Date:** ______________

Interviewer Signature: ______________________________ **Date:** ______________

Patient Name:_______________________ **Age:**______ **Medical Record #:**______________ **Date:**______________

Interviewer Notes:

- ☐ Safer sex and condom use reviewed
- ☐ ECP discussed
- ☐ HIV testing offered
- ☐ STI Risk Assessment done
- ☐ Pt. urged to discuss visit with parent/guardian

Interviewer Signature: ______________________________

OBJECTIVE:

Laboratory:

No	Yes		Pos	Neg
☐	☐	Chlamydia – Cervix /Urine /Urethra	☐	☐
☐	☐	GC – Cervix /Urine /Urethra	☐	☐
☐	☐	Herpes Culture	☐	☐
☐	☐	HIV	☐	☐
☐	☐	RPR	☐	☐
☐	☐	Other ________	☐	☐

Wet Mount: ☐ No ☐ Yes pH ______ WBCs __________ Clue Cells ______
Whiff : ☐ Neg ☐ Pos ☐N/A Hyphae ______ Trich ______

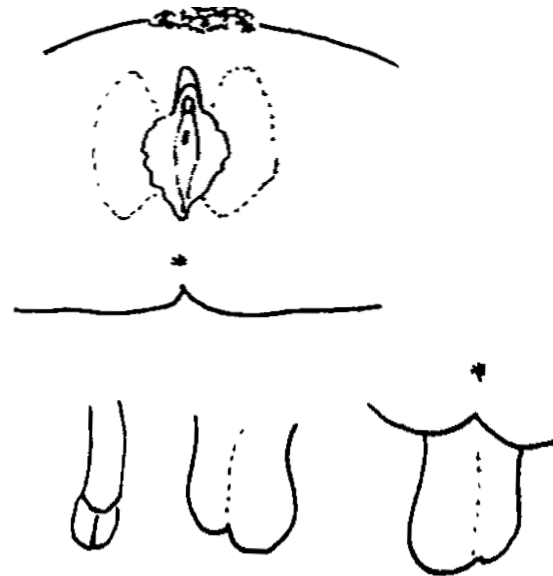
UTI Dipstick: Glucose _____ Protein _____ Nitrites _____ Leukocytes ______

Medical Examination:

1. Constitution:
   BP: ________ Temp: _______

	Normal	Variant	Not done
2. Skin	☐	☐	☐
3. Lymph	☐	☐	☐
4. Abdomen	☐	☐	☐
5. Genitourinary - Female			
Urethra	☐	☐	☐
Vulva	☐	☐	☐
Vagina	☐	☐	☐
Cervix	☐	☐	☐
Uterus	☐	☐	☐
Adnexa R	☐	☐	☐
L	☐	☐	☐
6. Genitourinary – Male			
Penis	☐	☐	☐
Scrotum	☐	☐	☐
Testes	☐	☐	☐
7. Gastrointestinal			
Rectal inspection	☐	☐	☐

8. Psychological – Acute distress ☐ No ☐ Yes



Dorsal Ventral Anterior Posterior

☐ Self- Testicular Exam Taught/ Pamphlet given ☐ N/A

ASSESSMENT AND PLAN:

☐ Pt. approved for UPT/STI Screen PRN

Pt. OK for ECP x 1 year: ☐ No ☐ Yes ☐ N/A

Plan B ________ LoOvral 8/Levlen 8 ________

- ☐ Spent >50% of time counseling. Total time with clinician ___________
- ☐ Implications of not obtaining follow up as recommended discussed
- ☐ Additional fact sheets/CIIC given _________________________________

Clinician Signature: ____ **Date:** ________________________